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STRATEGIES FOR EXPANDING THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN [WIC] PARTICIPATION: A SURVEY OF WIC DIRECTORS

REPORT

OF THE

SELECT COMMITTEE ON HUNGER
U.S. HOUSE OF REPRESENTATIVES

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*Effective July 13, 1987.
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LETTER OF TRANSMITTAL

To: Members of the Select Committee on Hunger.

From: Mickey Leland, Chairman.

I am pleased to transmit to Committee Members the enclosed Committee Report, "Strategies for Expanding the Special Supplemental Food Program for Women, Infants and Children (WIC) Participation: A Survey of WIC Directors."

This report is based on the responses to a Select Committee questionnaire designed to examine, from the perspective of program directors, the barriers to participation and recommendations for eliminating these obstacles. The report also explores State and local innovations for caseload expansion. I would like to express appreciation to the 72 program directors and their staffs for their valuable contributions and support.

I submit this report with the hope that it will assist Congress in its consideration of legislation to reauthorize the WIC Program during the 101st Congress.

Sincerely,

MICKEY LELAND,
Chairman.

INTRODUCTION

Since its inception as a pilot project in 1972, the Special Supplemental Food Program for Women, Infants, and Children [WIC] has received broad bipartisan support in the Congress and positive recognition in the medical and nutrition communities, largely as a result of numerous studies indicating that it is a cost-effective health and nutrition program. WIC serves as an adjunct to health care during critical times of growth and development and is intended to prevent the occurrence of health problems and to improve the health status of program participants.

During this decade, the program has expanded to all States and funding has increased from $725 million in Fiscal Year 1980 to $1.929 billion in Fiscal Year 1989. Yet, the U.S. Department of Agriculture [USDA] reports that in 1984, the latest year for which eligibility projections based on health risk and income criteria are available, an estimated 40 percent of the 7.5 million individuals fully eligible to participate were enrolled in the program.[1]

During a number of hearings examining the effectiveness and accessibility of Federal food assistance programs, the Select Committee on Hunger has received testimony from WIC administrators, service providers, and participants identifying various barriers to participation in the program. Efforts to learn more about these obstacles led the Select Committee to develop a questionnaire which was distributed to the directors of all State, territorial, and tribal WIC programs during February 1988. The Select Committee received responses from 72 of the 92 programs contacted.

The following report is based on the responses to the Committee's questionnaire and an extensive review of information currently available on WIC Program operation. It addresses program participation rates and funding; barriers to participation identified by State programs; innovations implemented by States in efforts to expand participation; and, recommendations for improving program management and expanding program service.

[1] U.S., President, "White House Conference on Food, Nutrition, and Health," 1969, p. 38.

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STRATEGIES FOR EXPANDING THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN [WIC] PARTICIPATION: A SURVEY OF WIC DIRECTORS

OVERVIEW

The final report of the 1969 White House Conference on Food, Nutrition and Health strongly encouraged the development and implementation of Federal initiatives to combat the "hunger and malnutrition" problems plaguing many low-income pregnant and lactating women and infants.[2] Consequently, in 1972, Congress approved legislation creating the Special Supplemental Food Program for Women, Infants, and Children (WIC), thus establishing a mechanism for reducing the incidence of nutrition-related health problems among these population groups by providing: food supplements, access to maternal and child health care and nutrition education services. Through this national program, nutrition and health services are targeted to low-income pregnant women, infants and children up to the age of five. Postpartum women who are breastfeeding may receive care for up to one year after delivery; non-breastfeeding women are eligible to participate for up to six months postpartum.[3]

Eligibility Criteria

Among the aforementioned categories, participation is limited to individuals who are members of households in which the annual income is between 100 and 185 percent of the Office of Management and Budget (OMB) poverty guidelines. The maximum eligibility level, which is linked by law to the level for reduced-price meals in the National School Lunch Program, is currently 185 percent of poverty. States may set lower ceilings, provided they do not go below 100 percent of poverty. Currently, a majority of the states serve individuals with household incomes no greater than 185 percent.[4]

In addition to meeting the income criteria, prospective participants must be diagnosed by a health professional to be at nutritional risk. Each applicant is evaluated by a health care professional (i.e., physician, registered nurse, dietitian or nutritionist) who bases the determination of nutritional risk on information from blood tests, height and weight measurements, and 24-hour dietary recall. Criteria for nutritional risk certification include adolescent

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[2] U.S. Department of Agriculture, Food and Nutrition Service, Estimation of Elgibility for the WIC Program," July 1987, p. vii.

[3] "Code of Federal Regulations," Title 7, Section 246.7, January 1, 1988, p. 229.

[4] Food Research and Action Center [FRAC], "WIC Facts: National and State Profiles of the Special Supplemental Food Program for Women, Infants and Children," April 1988, pp. 13–17.

pregnancy; history of abnormal pregnancies or births; history of alcohol or drug abuse; insufficient diet; clinical or hemotological signs of nutrient deficiency; and, anthropometric indicators such as underweight, overweight, abnormal weight gain during pregnancy, low birthweight and child growth stunting. Once approved for participation in the program an individual must be recertified at regular intervals (usually every six months).[5]

Due to limited resources for the WIC Program, a priority system was developed to determine eligibility criteria for those considered at highest risk. The following rating system was established to assist in the targetting of services to these groups:

Priority I.—Pregnant and breastfeeding women, and infants demonstrating hemotological, anthropometric or otherwise medically-determined conditions indicating nutritional deficiency;

Priority II.—Infants up to 6 months old whose mothers participated in the program during pregnancy with demonstrated hemotological, anthropometric, or medically-determined nutritional deficiencies and infants whose mothers were at nutritional risk during pregnancy according to these same indicators but did not receive WIC care;

Priority III.—Children with hemotological, anthropometric or otherwise medically-determined nutritional deficiencies;

Priority IV.—Pregnant women, breastfeeding women and infants with an inadequate dietary pattern;

Priority V.—Children at nutritional risk because of an inadequate dietary pattern;

Priority VI.—Postpartum women at nutritional risk; and,

Priority VII.—Previous participants who may regress in nutritional status unless they receive continued WIC services.[6]

The established system of targetting has proven effective in assuring the delivery of services to the priority groups. According to an April 1986 study of WIC participants characteristics issued by USDA, in 1984 26.8 percent of the participants were determined Priority I; 10.3 percent were Priority II; 37.8 percent were Priority III; 4.1 percent were Priority IV; 11.4 percent were Priority V; 6.3 percent were Priority VI; and 0.6 percent were Priority VII.[7]

Upon implementation of the new priority system the Select Committee was alerted to the concerns of state WIC directors that the revision in priority for children might reduce their access to services. Seventeen (24.6 percent) of the seventy-two respondents to the Select Committee survey indicated that service to children had been seriously reduced; thirty-three respondents (47.8 percent) reported that service had been nominally reduced; and, nineteen directors (27.5 percent) stated that service to children had not been affected. One WIC director who reported no change in service for children already enrolled, noted there had been a decline in outreach to children not serviced. In this case, it is possible that the

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[5] "Federal Regulations," p. 227.
[6] Ibid., p. 228.
[7] U.S. Department of Agriculture, Food and Nutrition Service, "Study of WIC Participant and Program Characteristics," April 1986, p. xix.

priority system hindered expanded participation among children because efforts to encourage their participation were restricted.

Supplemental Food Provision

WIC food packages are designed to enhance the nutritional intake of participants. The components of the food package are prescribed by nutrition and health care professionals at the time of certification. The program offers six basic food packages which are tailored to the specific nutritional needs of individual participants. The packages consist of foods high in iron, calcium, protein, vitamin A and vitamin C—nutrients commonly missing from the diets of low-income households. The average package contains a combination of milk, eggs, fruit and vegetable juices, iron-fortified cereals and cheese, infant formula, dried beans or peas, and peanut butter.[8] The cost of a WIC food package varies by state, ranging from almost $60 in Alaska to $23 in Mississippi. The average food package cost is approximately $30 per month.[9]

WIC clinics currently use three methods to distribute food packages—warehouse distribution, home delivery or voucher. Of the programs surveyed, Mississippi is the only state in which all participants utilize the warehouse distribution system. Clients visit centrally-located warehouse facilities to obtain the foods they are specified to receive. Seven states (9.7 percent) combine the voucher and direct delivery systems to provide food packages to clients. In Vermont, participants receive food through a combination of the home delivery and non-voucher store pick-up systems. A number of large, rural states have found that transportation and personnel requirements are more costly for home delivery than for other delivery systems. Many of these programs, including New Mexico, Utah and Nevada, prefer the voucher system, which is the system utilized by 87.7 percent of the respondents to the Select Committee on Hunger questionnaire.

WIC vouchers are redeemable only for the foods prescribed at certification. Unlike food stamp coupons, WIC vouchers specify food products rather than dollar amounts. This system is popular among program directors and clients because: it is convenient for the client; it does not involve the transportation and personnel required for home delivery; it allows clients a broad choice of food brands; and, it also avoids the "handout" stigma which is sometimes associated with the other forms of delivery. Several survey respondents mentioned that they like the voucher system because it supports local merchants.

Nutrition Education

In addition to the actual provision of food, WIC mandates that nutrition education classes be offered to participants. It is required that no less than one sixth of the program's administrative funds be expanded on providing this service.[10] The goal is to educate par-

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[8] Research Triangle Institute and New York State Research Foundation for Mental Hygiene, "Evaluation of the Special Supplemental Food Program for Women, Infants, and Children [WIC]," Vol. I: Summary, 1986, p. I-2.

[9] FRAC, "WIC Facts," p. 41.

[10] "Federal Register," Vol. 53, No. 17, January 27, 1988, p. 2214.

ticipants so that they will maintain healthy nutritional habits for themselves and their children even after they are no longer enrolled in WIC. The first exposure to nutrition education is made at certification, and clinics must make an additional nutrition education contact during each client's certification period.[11] WIC also encourages breastfeeding as part of its education program.[12]

Health Care

WIC is clearly distinguished from other nutrition assistance programs by its role as an adjunct to health care. The program brings low-income women and children, many of whom traditionally lack access to health services, into the health care system. Many WIC clinics are located in health clinics, and others refer clients directly to local physicians or health clinics.[13] This process also occurs in reverse; it is not uncommon for physicians and health clinics to refer needy clients to local WIC centers.

Administration/Funding Formula

WIC is administered at the federal level by the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS). USDA regulates and distributes funds to state and territorial health departments and Indian Tribal Organizations, and offers technical assistance to states through its seven regional FNS offices. States allocate these monies to local agencies and clinics sponsoring WIC programs, and oversee general program operation. For service to Indian tribe members, Indian Tribal Organizations are authorized to operate programs independent of the states in which they are located.

Each state has the authority to certify local sponsoring agencies. Priority consideration is given to public and private non-profit health agencies which have the capacity to provide on-site pediatric and obstetric care; however, agencies with less direct health care linkages are eligible to sponsor programs as well.[14]

Eighty percent of federal WIC funds are allocated for food purchases; the remaining twenty percent is targeted for administrative and nutrition service costs. The existing formula for distributing federal food funds has been in effect since October 1, 1987. Under this computation, states receive "stability" funds based on the grant from the previous fiscal year. Remaining monies—"residual" or "equity" funds—are distributed with fifty percent targeted to states which serve a higher number of individuals at greatest nutritional risk, and fifty percent to those which serve a higher percentage of their overall eligible population. (See Appendix B.) The current formula for allocation of administrative and nutrition service funds has been in effect since April 1, 1988. Under these new guidelines, state funding levels are determined by the appropriation received the previous year and the number of participants served. The most significant revision in the former rule is the use

[11] "Federal Regulations," p. 229.
[12] Ibid., p. 241.
[13] Research Triangle Institute, "Evaluation," p. I-3.
[14] Ibid., p. I-3.

of past year participation to determine funding increases to cover prospective program growth. This change was made in an effort to provide funds more equitably by removing disincentives for expanding participation and by rewarding states taking steps to increase enrollment and target high-priority individuals.[15]

Under the formula, states receive "stability" funds to maintain previous year participation levels. Once these "stability" monies are allocated, "equity" funds are distributed among states for which there is a projected increase in participation, or for which parity grant levels are greater than "stability" funding levels. Parity grants are estimates of what administrative fund allocations would be if based entirely on participation levels, and are computed in two segments. Under the first segment of the computation, 80 percent of the available funds are allocated on a cost-per participant basis adjusted for caseload size. This procedure responds to the need for considering the higher per-participant costs in states with smaller caseloads. In the second segment of the computation, the remaining 20 percent of the funds are distributed on the basis of: 1) the state salary index (state salary average/national salary average); 2) the state targeting index (state ratio of Priority I participants/national ratio of Priority I participants); and, 3) the projected participation level for the state. These factors take into consideration the higher costs associated with serving high-risk individuals, as well as the higher salaries required in some states to attract personnel.[16] (See Appendix B.)

A majority of the respondents to the Select Committee survey expressed general satisfaction with the revised administrative and nutrition services funding formula. Fifteen percent of the responding WIC directors suggested that the caseload equity funds should be distributed at the beginning of the fiscal year to prevent fluctuations in the caseload. When interviewed further by telephone, one WIC director commented that while the formula itself is acceptable, the computer-generated projections for participation used in applying the formula lacked accuracy. Consequently, participation level increases are consistently underestimated and funding levels inadequate.

Program Effectiveness

Numerous studies examining the effectiveness of the WIC Program indicate the positive effects of participation. A 1984 General Accounting Office (GAO) assessment of major studies on the effectiveness of WIC reported that fewer low birthweight babies are born to women who participate in the program. The evaluation noted conclusions from six studies indicating that approximately 7.9 percent of the women participating in WIC delivered low birthweight infants compared to about 9.5 percent of the women in non-WIC comparison groups.[17] Conclusions of a 1986 study commis-

[15] "Federal Register," p. 2213.

[16] U.S., General Accounting Office, "WIC Evaluations Provide Some Favorable But No Conclusive Evidence on the Effects Expected for the Special Supplemental Food Program for Women, Infants, and Children," January 1984, p. iv.

[17] Research Triangle Institute, "Evaluation," p. II-2.

sioned by USDA reveal that the program has a significant effect on the quality of participant diets. The study also found that WIC participants experience longer gestation periods (by 1.4 days); there is a lower incidence of preterm delivery, especially among less educated participants;[18] and, infants born to WIC participants had higher birthweights (23–47 grams).[19]

According to the results of the evaluation, WIC has a significant effect on fetal mortality rates, which is responsive to the nutritional and physiological status of the mother.[20] On this basis, the National WIC Evaluation concluded that "the WIC program function(s) as much, or more, through improving the mother's physiological status during pregnancy than through changes in accessibility to, and use of, health services. This interpretation is also reflected by the significant improvements in duration of gestation and birthweight associated with the WIC program".[21]

Because the costs of neonatal intensive care and long-term hospitalization and health care for low birthweight children are expensive, the potential savings benefits of preventive measures such as proper prenatal health and nutrition care are significant. A 1986 report by the Office of Technology Assessment estimated that the U.S. health care system could save between $14,000 and $30,000 for each low-birthweight birth prevented.[22] According to a 1983 administrative petition filed with the Department of Health and Human Services by Public Advocates, the annual cost of providing noenatal intensive care and rehospitalization for low birthweight infants totalled approximately $638 million. The petition projected that with comprehensive prenatal care and a resulting decline in the incidence of low birthweight, the cost of such care would be reduced to $90 million—a savings of $548 million.[23]

BARRIERS TO PARTICIPATION

WIC directors surveyed by the Hunger Committee cite funding, restricted access to transportation, insufficient outreach and understaffing as the most significant barriers to participation. Forty-six percent of the program administrators reported that current funding prevented caseload expansion; 32 percent cited the lack of transportation; 21 percent indicated inadequate outreach; and, 14 percent noted staffing constraints.

FUNDING

WIC is not an entitlement program, and although the program has received consistent funding increases, appropriation levels have not been adequate to serve all persons eligible for benefits. The Congressional Budget Office estimates that it would cost approximately

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[18] Ibid., p. II-11.
[19] Ibid., p. V-2.
[20] U.S., Congress, Office of Technology Assessment, "Healthy Children: Investing in the Future," Summary, 1988, p. 8.
[21] Public Advocates, Inc., "An Administrative Petition to the United States Department of Health and Human Services to Reduce the Incidence of Low Birth Weight and Resultant Infant Mortality," San Francisco, 1983, p. 112.
[22] Office of Technology Assessment, "Healthy Children," p. 8.
[23] U.S., Congressional Budget Office, Preliminary Staff Estimate of Full Funding for the WIC Program, September 21, 1988.

$3.8 billion in Fiscal Year 1989 to serve all individuals who are eligible for WIC benefits.[24] (See Appendix I) In contrast, the WIC appropriation for Fiscal Year 1989 has been set at $1.9 billion.

In Minnesota, the current waiting list is 3,000—5 percent of the caseload. The California WIC program reported that based on 1985–1986 participation, 78 percent of the individuals eligible were unserved in that state. Inadequate funding directly affects enrollment rates because it limits the funds available to cover the expense of food and health care services for clients. It also affects enrollment indirectly by causing staff shortages and limiting resources available for outreach.

Twenty-six directors report difficulties handling caseloads due to understaffing, shortage of professional staff, high rates of staff turnover, or inadequate administrative funding. Clinics experiencing funding constraints cannot offer adequate salary or benefit levels to attract the most qualified applicants for staff positions, nor can they maintain a sufficient number of staff positions. These conditions place a heavy burden on existing staff members and can lead to inefficient program operations and delayed services for applicants.

Along with insufficient funding levels, two WIC directors report problems with the one-year cycle for appropriations and funding delays, both of which impede long-term planning efforts. Because program administrators are uncertain of their budget allocations from year to year and are frequently uncertain as to when funds will actually reach them once appropriated, they are reluctant to increase caseloads and risk circumstances which would later force enrollment reductions. WIC directors surveyed by the Select Committee stressed the need for a funding mechanism which would assure the availability of funds at the beginning of the fiscal year to facilitate a smooth transition from one fiscal year to the next, and planning with some degree of confidence.

Clinic Accessibility

Twenty-two WIC directors report that transportation is a primary obstacle to participation. A number of potential program participants do not own cars or even have access to a car owned by someone else. They often cannot afford the cost of public transportation and many times lack physical access to such services, particularly in rural areas, where the distance to WIC clinics can be substantial. Directors note the need for an increase in the number of satellite clinics in rural areas, and for the development of programs to provide transportation to existing clinics.

In addition to transportation barriers, restricted clinic hours pose a problem for potential WIC participants. WIC directors from Wyoming, Idaho and Alabama commented that clients with daytime work hours have difficulty getting to clinics which are generally open only during normal working hours. For these clients, applying for or picking up WIC vouchers means taking time out from

[24] Maryland Food Committee, "Barriers to Participation in the Food Stamp and WIC Programs: The Client's Perspective," October 1987, p. 3.

work, which is inconvenient at best and expensive if the applicant is paid by the hour.

In testimony prepared for a Select Committee field hearing in Baltimore, Maryland, one WIC client cited transportation and the ability to secure time off from work for clinic appointments as major obstacles in accessing the program.[25] Iowa, perhaps, presents the most extreme example of the combined difficulties of transportation and schedule restrictions—services in the state are available in only one location in each county, and for one or two days per month at each location.

Cultural and Behavioral Barriers

Program directors in Maine, Montana, Wyoming, Maryland and New York, commented that many individuals perceive WIC as a "welfare" program and, thus, are reluctant to apply for benefits because of pride and a desire to avoid receipt of welfare benefits. The idea of receiving "handouts" in the form of supplemental food packages, or using vouchers instead of money to buy food in a local grocery store, is unattractive to some potential clients because it separates and identifies them as poor and unable to provide enough food for their families.

The perception that prenatal health care is unimportant or unnecessary among some potential WIC clients is a deterrent to participation. In many communities, pregnancy is considered a natural state; pregnant women do not need medical care unless complications arise—prenatal care is not a priority. The absence of a national health policy and lack of funding for universal prenatal care may have substantial impact on why many potential WIC participants perceive prenatal care to be unimportant or unnecessary.[26] In responding to the Select Committee survey, directors in Mississippi and Tennessee expressed frustration with the lack of client motivation to seek care early in pregnancy; the WIC Indian State Agency in Oklahoma noted that many of their clients did not understand the importance of nutrition education.

Although one of the primary goals of WIC is to prevent complications during and after pregnancy, for many participants, concern about the preventive component of the program is secondary to the more immediate need for food. Combatting emotional stress during pregnancy may take priority over health care concerns, especially for low-income single women. Understanding the attitudes of ethnic and low-income groups toward nutrition and health is crucial to efforts to encourage their acceptance of information and advice about prenatal care.

The family unit also plays an important role in the woman's decision to seek prenatal care, and can affect communication between WIC staff and participants. The absence of the baby's father can have a negative effect on the mother's motivation to seek and follow prenatal dietary and health advice. Family members are important for emotional support during pregnancy, and the absence of such support can affect motivation to seek care as well. The role

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[25] Healthy Mothers, Healthy Babies Coalition, "Healthy Mothers, Healthy Babies: A Compendium of Program Ideas for Serving Low-Income Women," January 1988, p. 6.

[26] Ibid., p. 6.

of a pregnant woman's mother can be especially important since she is often the most credible non-professional source of information on pregnancy for her daughter. If present, she can be a valuable ally for WIC staff by encouraging the woman to seek care and follow medical and nutritional advice. Staff which is not sensitive to the role of family members in health education, health care and nutritional habits is itself a barrier to expanded enrollment, since they will not be as capable of recognizing and overcoming potential barriers posed by family members or be able to take advantage of the assistance family members may provide for more effective communication and outreach.[27]

Communication and Coordination

The lack of communication and coordination at all levels of WIC administration (federal, state and local) is frequently cited in the survey responses as a significant barrier to effective and expanded service. One respondent to the Select Committee survey expressed particular concern about the length of time it takes to relay information on changes in regulations from federal to state and local agencies. Without quick access to this information, local agencies cannot accurately process clients or answer their questions.

Coordination with local private physicians and public health services is also critical to the success of local WIC programs. Physicians and health clinics are important referral agents for women and children eligible for WIC benefits and, as such, are valuable conduits for outreach. They are also important to those programs not directly linked to health clinics who must refer clients to outside health facilities. WIC directors from Maryland, Tennessee, Ohio and New Jersey reported a need in their states for improving coordination with local physicians and health clinics to strengthen and broaden referral systems.

Some states with large rural areas find it difficult to expand WIC into these areas because of the absence of available health services. For example, California, Indiana, Oklahoma and Texas reported that the lack of public health services for low-income children and pregnant women is a barrier to establishing WIC in unserved areas of their states due to the requirement that WIC be linked to health care facilities.

Coordination is also important to ensure that federal and local agencies providing care and benefits to the same target population do not duplicate services or interfere with one another. Currently, WIC and Maternal and Child Health Services perform a number of duplicate procedures such as hemotological tests for nutritional status determination.[28] The director of the Maryland WIC program cited "lack of coordination for * * * various eligibility intake procedures among local health departments" as a significant problem in that state.

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[27] Ibid., p. 3.
[28] FRAC, "WIC Facts," p. 19.

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Regulations

One WIC director surveyed stated that "more emphasis is placed on documentation/paperwork than on improved or responsive participant services." Substantial paperwork is required for applicant certification and verification, and for program monitoring and evaluation. Respondents from Washington, D.C., Massachusetts, North Carolina, Pennsylvania, Nebraska and New York suggested that requirements for participant processing and program evaluation be streamlined to reduce the administrative burden and increase the cost-effectiveness of these systems. To address these concerns, USDA has initiated a project to develop special software to assist smaller states in their data processing efforts.

According to one director, state and local WIC programs do not have the financial, technical or human resources to obtain and analyze the information requested in federal evaluations. For example, in Massachusetts, the state WIC office employs several full-time staff members for management evaluation alone; they are still overwhelmed because their management information system is not sophisticated enough to break down data into the categories requested in federal evaluation forms.

Program Abuse

A June 1988 USDA audit examining Food and Nutrition Service management of the WIC program reports that vendor and food purchase monitoring are areas vulnerable to fraud. This conclusion is based on purchases by USDA officials at 107 different non-chain stores in metropolitan areas in six states. The auditors found that: 1) 76.6 percent of the vendors overcharged for the food items purchased; and, 2) the rate of overcharge averaged 28.5 percent.[29]

The audit also examined dual participation rates among clients. Of 230 potential program abuse cases, sixty-six were confirmed as receiving duplicate benefits.[30] In responding to the Select Committee questionnaire, only one WIC director surveyed cited "repeated unauthorized purchases" as a problem for their state's program.

STATE EFFORTS TO EXPAND PARTICIPATION

State WIC agencies responding to the Select Committee questionnaire report implementation of a variety of projects to expand enrollment. They have directed most of their efforts toward overcoming the largest and most frequently cited barriers to participation—restricted access, inadequate outreach, insufficient funding and understaffing.

Accessibility

Numerous states have implemented mobile WIC clinics which travel to remote areas to certify, enroll and distribute vouchers to clients who might otherwise not be able to reach the clinic. Over-

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[29] U.S., Department of Agriculture, Office of the Inspector General, "Food and Nutrition Service Special Supplemental Food Program for Women, Infants, and Children Vendor Monitoring and Food Instrument Delivery Systems," June 1988, p. 1.

[30] FRAC, "Changes in the WIC Program Rules and Regulations," Washington, D.C., June 1985, p. 5.

coming transportation barriers by utilizing mobile clinics has been successful in rural regions in parts of Maine, Oklahoma, Alaska and Pennsylvania. Alaska's WIC program covers such a large area of scattered settlements that it distributes vouchers by mail to eliminate transportation costs altogether. Community health aides in Alaska perform nutritional risk evaluations and mail in the certification forms; the program then sends vouchers, nutrition education pamphlets and even food packages (when clients do not have access to a store) directly to the clients' homes.

Some states have established additional clinics in rural areas to make them more accessible. Some of these facilities are entirely separate clinics and others are satellites. Wyoming and Missouri have both increased the number of satellite clinics in efforts to expand enrollment in rural areas.

Extended hours of operation have improved accessibility for clients who work during the day in both Wyoming and Missouri where hours of operation include evenings and weekends. The New Jersey WIC program has implemented a statistical analysis software system developed by the Centers for Disease Control in Atlanta, Georgia, which charts the flow of patients through a particular clinic to give staff members an idea of peak and "dead" hours of operation. Hired consultants chart the movement of patients through the clinic, and then enter this data into the software. On the basis of the information entered, the computer advises the agency as to the most efficient schedule for hours of operation and staff lunch hours.

Outreach

Although all WIC Programs are required to operate an outreach component, regulations implemented in 1983 reduced Federal Government involvement in plans designed by the states to execute outreach activities. The resulting changes in the regulations no longer require states to: 1) give priority to the development of appropriate outreach materials; 2) give priority to referring clients to other programs; 3) set minimum standards for outreach programs; and, 4) target media outreach to high risk individuals.[31]

Nonetheless, states are required to target the most needy (those in the top categories of the priority system), and, in efforts to reach these individuals, they have developed and implemented a variety of creative outreach programs, often under considerable funding and staffing constraints. Some states use outside personnel to conduct outreach. For example, Utah reported using local advocacy groups to provide outreach services, and the District of Columbia utilizes volunteers. New Mexico has hired an outreach coordinator to assist in efforts to increase participation. Many state programs coordinate their outreach efforts with the Medicaid, Maternal and Child Health, Aid to Families with Dependent Children (AFDC), and Food Stamp Programs. Massachusetts sponsored a mailing campaign to AFDC recipients, pediatricians, obstetricians and licensed midwives. North Dakota targeted Food Stamp as well as

[31] Healthy Mothers, Healthy Babies Coalition, "Compendium," p. 55.

AFDC recipients for its mail outreach. The Amarillo, Texas program inserts WIC advertisements in water bills.[32]

To provide more effective publicity, WIC agencies have designed bilingual advertisements and education materials for potential clients with limited English skills. Many agencies also provide materials with little or no text for children and for adults with limited reading skills.[33] States have developed a variety of public information campaigns which range from grocery bag advertisements, subway posters, and television public service announcements, to tee shirt campaigns and "Bring-A-Friend" days. A WIC health center in Fayette, Mississippi sponsored a "Baby Day" for women with infants under seven months old. The day-long event included the provision of gift packs, demonstrations, videotape presentations, free health and nutrition evaluations for infants, counseling, and even prizes. Newspapers carried stories and photos of the event and, as a result, more women were informed, and subsequently applied for WIC benefits.[34]

Funding

STATE SUPPLEMENTAL FUNDING

Twenty-seven (37.5 percent) of the directors responding to the Select Committee survey reported receiving support from non-federal sources to augment their WIC allocations—eleven (15.3 percent) reported direct appropriations; eight (11.1 percent) reported receiving in-kind support; and, eight (11.1 percent) received a combination of cash and in-kind support. Programs described in-kind aid in such forms as clinic facility space, technical support (automated data processing system support), personnel, personnel benefits, utilities and copying services. Nineteen (26.3 percent) of the WIC programs receiving this supplemental support indicate that a portion of it is used to cover the administrative costs of increasing participation.

STATE CONTINGENCY FUNDS

Until recently, states were prohibited from carrying unexpended dollars into the succeeding fiscal year. Additionally, it was the sole responsibility of the state to cover the cost of any services exceeding the federal allocation. To avoid overspending, many states spent their federal WIC dollars conservatively, a practice which frequently resulted in fewer eligible persons receiving services and states returning "surplus" funds. In Fiscal Year 1986, only 12 states, territories and Indian reservations spent the full amount of federal WIC funding available to them; 65 underspent; and, eight overspent.[35]

Three respondents reported resolving the underspending dilemma by establishing contingency funds, for use in the event that the state WIC program overspends its federal WIC allotment. The sup-

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[32] Ibid., p. 58.
[33] Ibid., p. 59.
[34] FRAC, "WIC Facts," pp. 63-67.
[35] Center on Budget and Policy Priorities, "Legislative Update," Washington, D.C., January 13, 1988, p. 8.

plemental support is provided by the states and is readily available rather than scraped together in a last-minute funding crunch.

In response to the problems created by the carryover and backspending restrictions, Congress, during the 99th and 100th Congresses approved legislation to alter the regulations to help offset some of the need for contingency funds. The School Lunch and Child Nutrition Amendments of 1985 (P.L. 99-591) and the Commodity Distribution Reform Act and WIC Amendments of 1987 (P.L. 100-237) revised the program spending mechanisms to allow states to carry remaining funds into the next fiscal year; and to use funds from the succeeding fiscal year to cover current deficits, as long as the transferred amount is no more than one percent of the total budget for the upcoming next fiscal year.

THE IMPACT OF REBATE SYSTEMS

Several states have negotiated with infant formula companies to secure reductions in formula prices, thus, reducing overall program food costs to facilitate expansion. P.L. 100-237 permitted states to use cost savings from rebate systems states to acquire food items for additional participants and to cover a portion of administrative costs (based on the projected number of new participants).

The competitive bid rebate system permits states to solicit price bids from infant formula manufacturers for the purpose of establishing sole source contract agreements. The company offering the highest rebate is designated as the sole source provider of formula for the period specified in the contract. The rebate is remitted to the sponsoring agency on a monthly basis.[36]

In January 1987, Tennessee was the first state to initiate a rebate program of this type by contracting with Wyeth, a manufacturer of infant formula, to provide a $0.40 per can rebate. Considering that the retail cost of a can of infant formula ranges from $1.25 to $1.50, the rebate represents a savings of approximately 27 percent to 32 percent per container. It is estimated that the annual savings under the contract will total between $3 and $4 million, and that the state may be able to provide services to as many as 7,200 additional WIC recipients.[37]

In December 1987, Oregon instituted a competitive bid system. Wyeth signed a three year contract with the state health department which provides for a $0.60 rebate per can of formula purchased by WIC recipients at retail establishments. The contract specifies that the per-container rebate will correspond to formula market price increases.[38]

In May 1988, Texas launched a competitive bid rebate system which, it is estimated, will result in program savings totalling approximately $3 million per month. The Texas Department of Health anticipates that the funding generated by the rebate will permit a 40-percent expansion in WIC caseload. Local WIC directors plan to expand programs in underserved areas of Dallas, San

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[36] Ibid., p. 14.

[37] Texas Association of Community Action Agencies, "Food Journal," Vol. 2, No. 9, May 2, 1988, pp. 1-2.

[38] Community Nutrition Institute, "Nutrition Week," Vol. 18, No. 23, June 9, 1988, pp. 4-5.

Antonio and Houston, as well as establish new programs in counties currently unserved by WIC.[39]

In June 1988, Alabama and Nevada reached a competitive-bid rebate agreement with Ross Laboratories. Ross offered Alabama a $1.17 rebate per can of infant formula, the highest rebate bid to date. Alabama's WIC program will save an estimated $30 million over the 38-month contract period, enabling it to increase its income eligibility requirements from 150 to 185 percent of poverty and its caseload by an estimated 76,000 to 90,000 participants. Nevada signed a contract with Ross for a $0.92 per can rebate, and projects $1 million savings per year and an increase of 2,000 participants.[40]

In July 1988, Minnesota signed a 33-month contract with Ross Laboratories for a $1.15 rebate. The Minnesota WIC program will use the savings to add an estimated 10,500 new participants. They also received a $700,000 state grant to enable it to enroll one-third of these new participants in June, before receipt of any rebate money.[41]

The non-competitive bid model—the Open Market Rebate System—also permits WIC state agencies to solicit price bids for rebate amounts on infant formula. No priority is given to selecting the lowest bidder or designating any one company as the sole source provider. Therefore, states may contract with several companies to buy infant formula at varying prices and companies offering no rebate are not necessarily excluded from the process.

Florida and Wyoming were the first states to implement the non-competitive bid model. In October 1987, Mead Johnson offered the Florida WIC program a rebate of approximately $0.22 per can, Ross offered $0.20 per can, and Wyeth continued to offer infant formula at full price. Three companies offered comparable rebates in Wyoming; however, currently, the state has contracts only with Ross and Mead Johnson for $0.63 and $0.58 rebates, respectively.[42] Additionally, Michigan has implemented a non-competitive system with Ross offering a $0.50 rebate per can and Mead Johnson currently offering a $0.20 rebate per can.[43]

OTHER COST-SAVINGS MECHANISMS

A number of states have employed other innovative policies for reducing program food package costs without affecting the nutritional integrity of the program. Options for achieving this goal include eliminating more expensive foods from WIC food lists, educating clients in the art of comparative shopping and encouraging clients to use coupons. WIC programs in Puerto Rico, Rhode Island, and Oklahoma reduced food packages as part of their efforts to stretch funds and serve more people. Oklahoma reduced its food package by $3.50 per person per month, allowing a reported 8 percent growth rate in participation. WIC centers in Minnesota, Wash-

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[39] Center on Budget and Policy Priorities, "Legislative Update," January 13, 1988, p. 18.
[40] Ibid., p. 8.
[41] Ibid., p. 14.
[42] Center on Budget and Policy Priorities, "Savings to Serve More: Ways to Reduce WIC Infant Formula Costs," September 1988, p. 30.
[43] Community Nutrition Institute, "Nutrition Week," Vol. 18, No. 27, July 14, 1988, p. 1.

ington and New Mexico removed more expensive foods and food brands from their lists of WIC foods.

Until recently, federal law required that all savings from cost-reducing efforts go toward the purchase of additional food; WIC agencies were not allowed to direct any of the savings to offset the administrative costs of serving additional participants. This regulation was altered with the enactment of P.L. 100–237 which allows WIC agencies to use up to 20 percent of the funds realized through rebate programs to cover administrative costs for program expansion.

STAFFING

Many community service agencies rely on volunteers and paraprofessionals to help relieve the pressures of understaffing, and WIC is no exception. The WIC program in Washington, D.C. uses volunteers in a variety of areas, depending on the individual volunteer's background. For example, volunteers with training in nutrition or health may help with determinations, nutrition education, counseling and outreach; others relieve staff of clerical and telephone duties such as follow-up calls, scheduling appointments, screening and referral. Oregon reported that its WIC program utilizes volunteer resources for similar services.

AUTOMATED DATA PROCESSING SYSTEMS

Some states report having been able to automate certain aspects of the application and certification process. Automated Data Processing systems (ADPs) accelerate these procedures by reducing paperwork, freeing staff members to perform other functions, such as outreach and nutrition education. In Wyoming, the Shoshone and Arapahoe WIC program has computerized participant files and check issuance procedures to release staff members for certification, outreach and nutrition education activities.

COORDINATION WITH OTHER HEALTH AND NUTRITION SERVICES

The Select Committee was advised by seventeen WIC directors that they have established communication networks and are coordinating their services with other social service agencies in the region. A program in Wyoming sends WIC staff members to local maternity and well-child clinics to provide information and WIC services to eligible clients. North Carolina's WIC program has joint outreach campaigns with Medicaid and Maternal and Child Health. By pooling money and staff resources through these and similar projects, related social service agencies can ease their individual funding and personnel constraints, while maintaining, and even expanding the delivery of services to people in need.

EXPANDED ELIGIBILITY CRITERIA

West Virginia recently raised its income eligibility level from 150 to 185 percent of poverty and expanded its nutrition risk criteria in efforts to serve a greater number of low-income persons in need of nutrition and health care services. High-risk postpartum women, formerly Priority IV clients, are now in the Priority III grouping, and regression clients are placed in their original priority level for

one certification period. Additionally, clients may be given "psychosocial" status, indicating living conditions (e.g., extreme poverty) which place a participant at a higher risk level than indicated solely by nutritional or health status. These clients may be assigned a higher priority status if such conditions are documented.

States have directed efforts and imagination toward developing strategies to stretch existing funds to serve more participants. They have redirected money, reduced program costs, pooled resources with other agencies and tapped volunteer manpower within their communities for projects designed to expand enrollment. They have worked to simplify application and participation procedures and educated their communities about the benefits of WIC in order to encourage otherwise reluctant clients to apply. While the constraints imposed by funding limitations remain a primary obstacle to assuring the availability of services to all persons eligible for WIC benefits, the state and local programs have achieved extraordinary gains in bringing services to individuals in need.

RECOMMENDATIONS

Respondents to the Select Committee on Hunger survey have offered the following recommendations to improve program operation and facilitate expansion:

Funding

1. Funding should be increased to assure the availability of services to a greater number of eligible individuals.
2. The administrative spending cap should be increased from its current level of 20 percent, and direct service costs (e.g., nutrition education and outreach) should be considered separately from other administrative costs.
3. Federal funds should be distributed earlier in the fiscal year and possibly awarded on a multi-year basis to encourage more confidence for long-term planning and enrollment expansion.

Transportation

1. Local WIC agencies should utilize community volunteer drivers to reduce transportation barriers, and encourage participants who own cars to form carpools. To the extent possible, local WIC programs should endeavor to coordinate transportation services with other nearby health and social service agencies.

Communication/Coordination

1. Greater efforts should be made to improve the coordination of WIC and MCH services.
2. Local WIC programs should establish advisory committees comprising membership of local health professionals, community members, participants and WIC administrators officials to develop improved communication among service providers and to expand outreach conduits.

Eligibility

1. Medicaid recipients (who fall within the WIC population categories) should be categorically eligible for WIC benefits.
2. The definition of a household should be revised to permit separate household status for pregnant teenagers who reside with their parents, and to count a pregnant woman as two individuals.
3. Military housing allowances for families living off-base should not be counted as income when determining income eligibility.

Outreach

1. Efforts should be made to educate the media and encourage their cooperation in distributing information about WIC.
2. Programs should encourage the involvement of current and former participants in outreach efforts.

Program Management/Simplification

1. The Federal Government should provide funding and technical assistance for the implementation of automated data processing and management information systems in WIC agencies.
2. State agencies should improve initial staff training and fortify efforts to assure that staff is knowledgeable about program revisions mandated by legislation and regulation.
3. The Federal Government should streamline program monitoring and evaluation requirements.
4. The Federal Government should sponsor a patient-flow analysis system to determine how to utilize staff and facilities most efficiently.

MINORITY STAFF VIEWS

The WIC program has enjoyed broad bipartisan support in Congress. The Minority agrees with much of this report, but has some reservations about specific portions and disagrees with some of the reported recommendations.

Due to budget constraints, the WIC program is not an open-ended entitlement program, but instead must operate within the funding levels provided each year by the Congress. Thus, the number of eligible women, infants, and children accepted into the program depends on the amount of federal funds made available for the program.

It is important to emphasize that WIC has grown rapidly in funding, participation and number of clinics since its inception. In ten years, the WIC program has expanded to all states, with funding increasing from $725 million in Fiscal Year 80 to $1.802 billion in Fiscal Year 88. Although the report states that only about 40 percent of those eligible are being served, the program continues to achieve its goal of serving the most eligible recipients. A priority system was established to assist in targeting services to those most at need. Although the respondents to the survey claim that the priority system now used by WIC reduces the access of children to WIC services, the key groups, such as pregnant women and infants, continue to get priority. Because these groups are considered more at risk, they have received more from the program's limited resources.

Twenty-six of the seventy-two respondents reported difficulties in handling caseloads due to severe understaffing, shortages of professional staff, and high rates of staff turnover. These respondents also stated that these conditions placed a heavy burden on existing staff members and led to inefficient program operations and delayed services. A recently completed unpublished study by the Food and Nutrition Service on administrative costs in the WIC program did *not* observe high turnover rates. The staff tenure averaged two to three years, with clerical staff averaging significantly longer times.

Although many respondents noted that potential recipients did not realize the health risks involved in not seeking adequate prenatal care, or the importance of good nutrition education, the states are required to inform clients of other programs and alternatives available to them if they are not eligible for WIC. Those clients who cannot get WIC benefits are informed of other assistance programs such as Food Stamps and Aid to Families with Dependent Children. The Food Stamp Program, for example, is an entitlement program that is available to all eligible recipients to help improve the level of nutrition of low-income households.

The Minority has serious concerns about several of the recommendations made by the respondents to the survey. It is important

to note that Committee Members have not expressed a position on these recommendations and that they are solely those of the respondents.

Among those surveyed, particular attention was focused on the distribution of federal funds earlier in the Fiscal Year and the desirability of awarding them on a multi-year basis. Such changes in the allocation of federal funds would have significant effects on fiscal policy and the budget deficit that deserve further study. Legislative changes would also be required in the appropriations process.

Some of those surveyed also suggested that military housing allowances for families living off-base should not be counted as income. This recommendation represents a fundamental misunderstanding of military pay scales and policies. Housing allowances are an integral part of military pay. There is no justification for treating the income of military families any differently than income of other families.

Respondents to the survey also recommended that the definition of a household should be revised to permit separate household status for pregnant teenagers who reside with their parents, and to count a pregnant woman as two persons. The Minority believes that eligibility of dependents, including pregnant teenagers, should be determined by total household income. There is no reason why the pregnant, minor child of parents who earn $50,000 should be on public assistance. The recommendation that a pregnant women be regarded as two persons is an intriguing concept with which many Minority Members might agree. It does appear, however, that this recommendation is not viable under the Supreme Court's decision in *Roe* v. *Wade* that a fetus before the third trimester of pregnancy is not included in the fifth amendment's protection against deprivation of "life, liberty, or property, without due process of law." So long as the Supreme Court continues to hold that a fetus is not a person, granting it federal benefits as a separate individual is impossible. Many Minority Members, however, would welcome the opportunity to change this situation in the context of wider reforms in abortion law.

BIBLIOGRAPHY

American Academy of Pediatrics. "Report of the Task Force on the Assessment of the Scientific Evidence Relating to Infant-Feeding Practices and Infant Health." "Pediatrics," Vol. 74, No. 4, Pt. 2, (October 1984).

Center on Budget and Policy Priorities. "Memo to WIC Advocates and WIC Administrators." Washington, D.C.: Center on Budget and Policy Priorities, January 13, 1988.

Center on Budget and Policy Priorities. "Saving to Serve More: Ways to Reduce WIC Formula Costs." Washington, D.C.: Center on Budget and Policy Priorities, 1988.

"Code of Federal Regulations." Title 7, Section 246.7. Washington, D.C.: Government Printing Office, 1988.

Community Food Resource Center. "Community Food Resource Guide." New York: Community Food Resource Center, 1987.

Community Nutrition Institute. "Nutrition Week." Vol. 18, No. 23. Washington, D.C.: Community Nutrition Institute, June 9, 1988.

Community Nutrition Institute. "Nutrition Week." Vol. 18, No. 27. Washington, D.C.: Community Nutrition Institute, July 14, 1988.

Committee to Study the Prevention of Low Birthweight. "Preventing Low Birthweight." Wasington, D.C.: National Academy Press, 1985.

"Federal Register." Vol. 52, No. 127. Washington, D.C.: Government Printing Office, July 2, 1987.

"Federal Register." Vol. 53, No. 17. Washington, D.C.: Government Printing Office, January 27, 1988.

Food Research and Action Center. "Crisis and Opportunity Enhancing the Role of Nutrition in Maternal and Infant Health," Proceedings of a national conference held in Washington, D.C., January 16 and 27, 1986.

Food Research and Action Center. "WIC Facts: National and State Profiles of the Special Supplemental Food Program for Women, Infants and Children." Washington, D.C.: Food Research and Action Center, 1988.

Food Research and Action Center. "WIC: A Success Story." Washington, D.C.: Food Research and Action Center, 1981.

Food Research and Action Center. "Changes in the WIC Program Rules and Regulations." Washington, D.C.: Food Research and Action Center, 1985.

Food Research and Action Center. "Poor Infants, Poor Chances." Washington, D.C.: Food Research and Action Center, 1987.

Healthy Mothers, Healthy Babies Coalition. "Healthy Mothers, Healthy Babies: A Compendium of Program Ideas for Serving Low-Income Women." Washington, D.C.: Government Printing Office, 1988.

Jones, Jean Yavis. "Special Supplemental Food Program for Women, Infants, and Children (WIC): Description, History, and Data." Washington, D.C.: Government Printing Office, 1986.

Jones, Jean Yavis. "Chronology and Brief Description of Federal Food Assistance Legislation, 1935–1987." Washington, D.C.: Government Printing Office, 1988.

Jones, Jean Yavis. "Child Nutrition Program Information and Data." Washington, D.C., 1988.

Laurence, Patricia, Maryland Food Committee, "Barriers to the Food Stamp and WIC Programs: The Client's Perspective." Statement presented to the House Select Committee on Hunger at a field hearing in Baltimore, Md., October 2, 1987.

Paige, David M., and Krietner, Marianne. "The USDA WIC Program: An Administrative Overview." Evanston: Mead Johnson and Company, 1977.

Public Advocates, Inc. "Administrative Petition to Reduce the Incidence of Low Birth Weight and Resultant Infant Mortality." An administrative petition to the U.S. Department of Health and Human Services, 1983.

Texas Association of Community Action Agencies. "Food Journal." Vol. 2, No. 9. Austin: Texas Association of Community Action Agencies, May 2, 1988.

U.S. Congress. Congressional Budget Office. "Reducing Poverty Among Children." Washington, D.C.: Government Printing Office, 1985.

U.S. Congress. Congressional Budget Office. Cost estimate of full participation in WIC for Fiscal Year 1989 prepared for the House Select Committee on Hunger. October 1988.

U.S. Congress. Office of Technology Assessment. "Healthy Children: Investing in the Future." Washington, D.C.: Government Printing Office, 1988.

U.S., Department of Agriculture, Food and Nutrition Service. "Annual Historical Overview of FNS Programs, Fiscal Year 1986." Washington, D.C.: Government Printing Office, 1987.

U.S., Department of Agriculture, Food and Nutrition Service, "Estimation of Eligibility for the WIC Program: Report of the WIC Eligibility Study." Washington, D.C.: Government Printing Office, 1987.

U.S., Department of Agriculture, Office of the Inspector General. "Food and Nutrition Service Special Supplemental Food Program for Women, Infants, and Children Vendor Monitoring and Food Instrument Delivery Systems." Audit Report No. 27661-2-Ch, Washington, D.C. Government Printing Office, 1988.

U.S., Department of Agriculture, Food and Nutrition Service. "Report on WIC Nutrition Education Services." Washington, D.C.: Government Printing Office, 1986.

U.S., Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "Improving MCH/WIC Coordination: Final Report and Guide to Good Practices." Washington, D.C.: Government Printing Office, 1986.

U.S., General Accounting Office. "WIC Evaluations Provide Some Favorable But No Conclusive Evidence on the Effects Expected for the Special Supplemental Food Program for Women, Infants and Children." (Report to the Committee on Agriculture, Nutrition, and Forestry, U.S. Senate), Washington, D.C.: Government Printing Office, 1984.

U.S., General Accounting Office. "Special Supplemental Food Program: Using Cost Saving Methods Could Increase Participation" (Briefing report to the Chairman, Subcommittee on Nutrition and Investigations, Committee on Agriculture, Nutrition, and Forestry, U.S. Senate), Washington, D.C.: Government Printing Office, 1987.

U.S. President. "White House Conference on Food Nutrition and Health (Final Report)." Washington, D.C.: Government Printing Office, 1969.

APPENDIX A

Chronology of the WIC Program

1969

Congress created the Commodity Supplemental Food Program [CSFP], through which federally purchased surplus commodities from the agricultural sector were distributed to low-income pregnant women, infants, and children under the age of six.

1972

Congress approved legislation authorizing creation of the Special Supplemental Food Program for Women, Infants, and Children (WIC). This two-year pilot project was to serve pregnant and postpartum women, infants, and children to age four (rather than to age six as under CSFP). In addition to meeting the income guidelines, it was required that applicants display physiological or epidemiological signs that their health was at risk due to poor nutrition.

Responsibility for administration at the federal level was placed with the United States Department of Agriculture Food and Nutrition Service [USDA/FNS]. Federal funds were to be distributed to State health departments for allocation to local agencies operating WIC programs. The USDA set up a task force to design the operating guidelines for the project.

Congress appropriated $20 million (of section 32 funds) for FY 1973 and authorized $20 million for FY 1974. Up to 10 percent of the total budget for each fiscal year was allowed for administrative costs.

1973

A class action suit was filed against the USDA by the Food Research and Action Center to force expedited establishment of the regulations and to ensure that all the money appropriated was spent. The court ruled in favor of the plaintiffs, and on August 29, 1973, the first WIC project was approved.

1974

In recognition of the complexity and expense of medical evaluation procedures required for nutritional risk certification, USDA established new regulations which allowed clinic evaluation costs to exceed the 10 percent administrative spending limit.

Congress extended WIC through FY 1975 and authorized $40 million (P.L. 93-150). Later raised the funding level to $100 million for FY 1975 (P.L. 93-326).

1975

WIC officially became a national health and nutrition program (as established by P.L. 93–150). At this time Congress authorized Indian tribes, bands, and groups to act as state agencies in the administration of WIC programs.

The administrative spending cap was increased from 10 to 20 percent, and allowed start-up and nutrition education costs as administrative expenses. Congress also expanded eligibility for the program, extending it to nursing mothers for a period of one year postpartum, to postpartum non-nursing women up to six months, and to children up to the age of five.

1976

A class action suit was filed against the USDA in an effort to require it to allocate allegedly unspent funds from FY 1974 and FY 1975. The plaintiffs won the case, and USDA was required to spend $125 million left over from FY 1974 and 1975, and $62.5 million for the three-month period during which the beginning of the fiscal year was changed from July 1 to October 1. It was also ordered to spend the full funding amounts authorized for FY 1977 and FY 1978.

1978

Congress extended the WIC program through FY 1982. Authorized $550 million for FY 1979, and $800 million for FY 1980 (later reduced to $750 million in a compromise with the Administration). These levels were required by law to be fully appropriated. The amendments also authorized $900 million for FY 1981, $950 million for FY 1982, but did not require full appropriation of these amounts.

Congress also enacted a number of amendments which included substantial changes in WIC eligibility requirements (P.L. 95–627). These amendments specified that the maximum income eligibility level be set at the level required to qualify for reduced-price school meals under the National School Lunch Act. In 1978 this level was 195 percent of the Secretary of Agriculture's income poverty guidelines (the Office of Management and Budget guidelines adjusted for inflation). States could set their own lower limits as long as they did not go below 100 percent of poverty.

The amendments required that a health care professional (i.e., nurse, physician, nutritionist, or dietrician) be the one to certify that an applicant is at nutritional risk, and to prescribe the appropriate supplemental foods. They also required the provision of nutrition education for program participants, and that no less than one-sixth of available administrative funds be devoted to this activity.

Additionally, the legislation required states to increase outreach efforts and to increase cooperation with local organizations to reach more potentially eligible groups.

1980

The Omnibus Budget Reconciliation Act extended WIC through 1984, and revised the standard for maximum income eligibility from 195 percent of the USDA poverty guidelines to 195 percent of the Office of Management and Budget guidelines.

1981

Budget reconciliation legislation lowered the maximum income eligibility level for reduced-price school meals from 195 to 185 percent of poverty, thereby lowering the eligibility level for WIC (1981 OBRA).

1986

The Continuing Resolution for Fiscal Year 1987 (P.L. 99–591) included provisions of H.R. 7, the School Lunch and Child Nutrition Amendments of 1986. The bill reauthorized WIC through fiscal year 1989.

1988

H.R. 1340 signed into law (P.L. 100–237). Allows WIC agencies to use up to 20 percent of cost savings from infant formula rebates toward the administrative costs of increasing participation. Also allows carry-over and backspending of funds up to 1 percent of the total grant for the next fiscal year.

APPENDIX B

Formula for Allocating Administrative and Nutrition Services

I. STABILITY FUNDS

A. Objective: Maintain current level of participation.
B. Criteria: Administrative funding level for previous fiscal year.

II. RESIDUAL FUNDS ("GROWTH" OR "EQUITY")

A. Objectives: To reward state efforts for increasing participation and to take into account variations in per-participant costs when determining funding levels.
B. Criteria: Grant amount is the larger of:

1. Stability funds *plus* funds commensurate with projected increase in participation level (as determined by FNS), or
2. Parity funding level, which is the projected total administrative funding level—stability plus residual—if based entirely on participation level and variations in per-participant costs. The calculation includes:
   (a) Variations in per-participant costs (higher for small caseload)
   (b) Variations in salary levels
   (c) Costs associated with service to a larger percentage of high-risk participants (more effective targeting)

Federal Register. Vol. 53, No. 17, January 27, 1988, p. 2221.

Formula for Food Funding Allocation

I. STABILITY FUNDS

A. Objective: Maintain current levels of participation.
B. Criteria: Food grant level from the previous fiscal year.

II. RESIDUAL FUNDS

A. Objective: To distribute more funds based on participation rates and per-participant costs.
B. Criteria:

1. Fifty percent distributed to states which serve larger numbers of high nutritional-risk individuals.
2. Fifty percent distributed to states which serve a higher percentage of the eligible population.

Federal Register. Vol. 52, No. 127, July 2, 1987, p. 25190.

APPENDIX C

WIC Participation Trends

(BY WIC CATEGORY)

The estimated level of WIC program coverage varies substantially among categories of WIC participants. For instance, in 1984, breastfeeding women and children appear to have been relatively least served (27 and 32 percent respectively) while eligible pregnant and postpartum women and infants appear to have been most fully served (46 and 67 percent). On the basis of these estimates, it appears that the WIC Program does target its benefits to the two categories of persons of greater priority concern, which are pregnant women and infants.

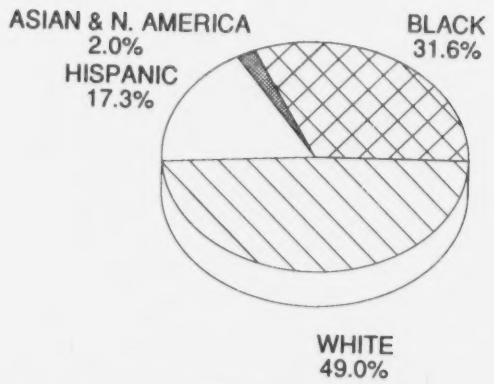
[In percent]

WIC participant groups	Estimated percent of eligible population participating in WIC		Change in estimated WIC Program coverage 1979 to 1984
	1979	1984	
Pregnant women	27.3	46.1	+68.7
Postpartum women	39.5	46.5	+17.6
Breastfeeding women	11.5	27.1	+134.9
All women	26.7	41.5	+55.5
Infants	42.5	66.9	+57.4
Children	22.7	32.4	+43.0
All WIC	26.8	39.9	+48.7

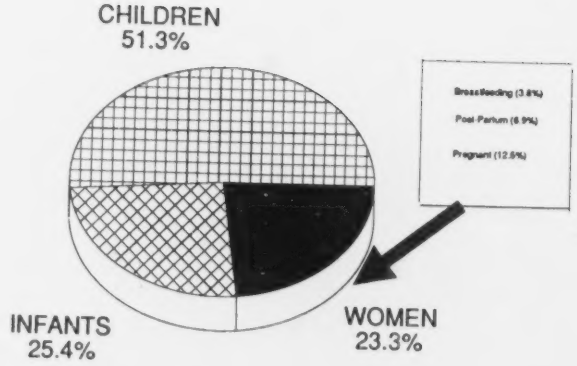
Information provided by FNS/Management Information Division.

APPENDIX D

ETHNIC AND WIC FACTS



ETHNICITY

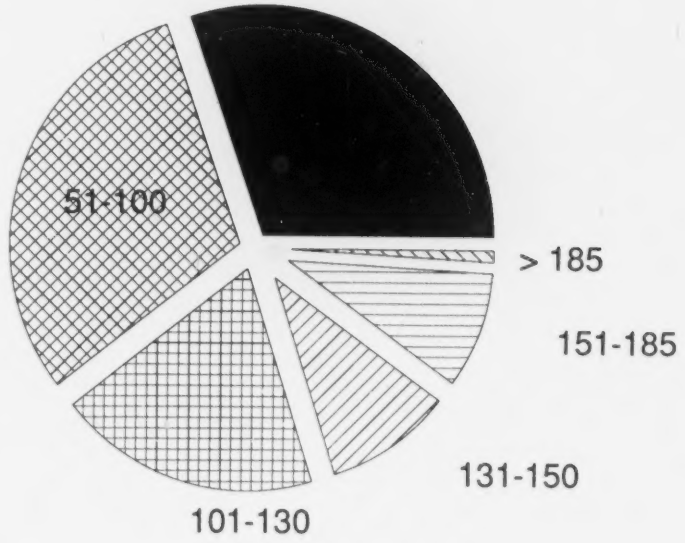


WIC CATEGORY

FOR "PRIORITY" AND " INCOME" BREAKDOWN,
SEE pp. xix and xxi

APPENDIX E

PERCENT OF POVERTY
FOR WIC PARTICIPANTS



base on reported cash income
Aug. - Dec. 1984

APPENDIX F

TOTAL FEDERAL DOLLARS SPENT FISCAL YEAR 1980—FISCAL YEAR 1988

Women, Infants, and Children

[In millions]

Fiscal year:	
1980	$725
1981	869
1982	948
1983	1,123
1984	1,386
1985	1,488
1986	1,581
1987	1,681
1988	*1,802

*Estimate.

APPENDIX G

Fiscal Year 1987 Equity Allocation

Region and State	*Equity funds*
Southwestern:	
Arkansas	$963,799
New Mexico	621,591
Oklahoma	329,090
Texas	4,421,972
Tonkawa	137
Zuni	9,882
Mountain Plains:	
Colorado	727,233
Iowa	552,670
Kansas	821,985
Missouri	469,678
Montana	143,583
Nebraska	573,740
South Dakota	402,355
Utah	928,856
Western:	
Alaska	83,036
Arizona	757,549
California	4,816,616
Hawaii	861,120
Idaho	62,500
Oregon	138,947
Washington	976,955
Guam	70,189
New England:	
Maine	159,440
Massachusetts	297,961
North Atlantic:	
Delaware	182,158
New Jersey	1,145,687
Pennsylvania	1,485,063
Puerto Rico	2,531,967
Virginia	726,364
West Virginia	310,112
Southeastern:	
Alabama	1,058,968
Florida	3,268,446
Tennessee	902,395
Midwestern:	
Illinois	1,707,345
Indiana	1,597,681
Total	34,116,970

APPENDIX H

SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN PROGRAM PARTICIPATION AND EXPENDITURES—REGIONAL TOTALS

Region/State	Clinics operating	Average participation	Federal dollars	Average food cost per person
1983				
Northeast	950	357,313	$161,403,753	30.09
Mid-Atlantic	1,121	381,802	158,502,174	27.96
Southeast	1,399	532,834	235,478,314	29.52
Midwest	1,132	450,886	181,051,152	26.54
Southwest	684	301,027	142,860,374	31.78
Mountain Plains	995	201,188	85,779,545	27.73
Western	1,356	311,916	158,364,989	34.76
1984				
Northeast	949	418,063	197,350,541	31.60
Mid-Atlantic	1,121	455,018	200,164,998	30.04
Southeast	1,398	627,502	282,909,918	30.17
Midwest	1,132	593,499	240,434,558	27.06
Southwest	684	361,965	178,404,000	33.09
Mountain Plains	995	228,335	100,324,727	28.79
Western	1,356	360,389	186,416,409	35.15
1985				
Northeast	1,099	409,758	205,571,231	33.36
Mid-Atlantic	1,203	473,070	217,044,605	31.23
Southeast	1,429	649,521	300,326,476	30.80
Midwest	1,387	592,397	252,387,010	28.20
Southwest	798	383,961	194,958,550	33.96
Mountain Plains	1,169	234,828	110,371,941	30.73
Western	1,082	394,449	206,701,375	35.54
1986				
Northeast	1,097	399,787	212,474,762	35.13
Mid-Atlantic	1,189	494,092	232,659,001	31.88
Southeast	1,429	697,892	320,806,692	30.59
Midwest	1,387	635,931	264,610,819	27.40
Southwest	798	414,677	211,853,266	34.20
Mountain Plains	1,169	250,465	118,912,053	31.11
Western	1,082	418,823	219,007,322	35.34
1987				
Northeast	996	414,546	(1)	(2)
Mid-Atlantic	1,139	502,633	(1)	(2)
Southeast	1,588	720,361	(1)	(2)
Midwest	1,233	652,088	(1)	(2)
Southwest	782	427,369	(1)	(2)
Mountain Plains	1,149	263,303	(1)	(2)
Western	1,091	444,910	(1)	(2)

[1] Federal expenditures and food cost per person figures unavailable for 1987.
[2] Information provided by FNS/Management Information Division.

APPENDIX I

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 4, 1988.

Hon. MICKEY LELAND,
Chairman, Select Committee on Hunger,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: In response to your recent request, the Congressional Budget Office has estimated the cost of full funding for the Special Supplemental Food Program for Women, Infants and Children [WIC] for fiscal year 1989. Full funding for the WIC program in 1989 is estimated to cost $3.8 billion, which represents a $1.9 billion increase above the 1989 appropriation of $1.9 billion. The basis for this estimate is discussed below.

The Special Supplemental Food Program for Women, Infants and Children (WIC) provides monthly food packages or food vouchers to low-income women, infants and children who are at nutritional risk. Eligible participants include pregnant women, postpartum women (up to six months after delivery), breast-feeding women (up to twelve months after delivery), and infants and children under age five whose income is below 185 percent of the OMB poverty guidelines. Participants must also be judged by a competent health professional to be at nutritional risk based on criteria such as abnormal height or weight, anemia, a history of high-risk pregnancies, inadequate dietary patterns or other conditions.

An estimated 9.4 million pregnant and postpartum women, infants and children under five years of age were eligible for WIC in 1985 under income criteria for the program. This estimate is based on a CBO analysis of the Current Population Survey (March 1986) and data from the 1980 Census for Puerto Rico, Guam and the Virgin Islands. A recent study has used national health and dietary survey data to estimate that 77 percent of the WIC income-eligible population also meet the nutritional risk criteria.[1] Applying this adjustment reduces the eligible population to 7.3 million people who are eligible under both income and nutritional criteria.

Providing benefits to all 7.3 million fully eligible people is estimated to cost $3.8 billion in 1989, based on an average monthly cost of $44 per person. The 1989 appropriation level for WIC is $1.9 billion, which will fund benefits for an estimated 3.7 million people per month at the same cost per person.

[1] United States Department of Agriculture, Food and Nutrition Service, Estimation of Eligibility for the WIC Program, July 1987.

These estimates are subject to several qualifications. The income-eligible population estimate includes all households with incomes of less than 185 percent of the poverty level, even though a few states and localities use lower income limits. This source of overestimation may be more than offset by the fact the estimate does not include poor family or sub-family units living within wealthier households, and it uses annual rather than monthly income. Furthermore, the estimate does not allow for any growth in the number of poor women, infants, and children between 1985 and 1989.

The estimate that 77 percent of the income-eligible population meet the nutritional risk eligibility criteria is also uncertain. The nutritional risk estimate is based on national surveys that were not specifically designed to measure nutritional risk among the WIC-eligible populations. In addition, the estimate does not reflect state variations in establishing nutritional risk criteria. Finally, actual risk determinations made by medical professionals conducting WIC certification interviews may differ from determinations based on survey data.

The average monthly cost of $44 per person includes $35 in food costs and $9 in administrative costs. These costs are based on 1987 costs, adjusted for projected inflation. Average costs could be lower under an expanded program, because many of the new participants would be children and postpartum women, who receive less costly food packages.

If you wish further details on this estimate, we will be pleased to provide them. Julie Isaacs (226-2820) is the CBO staff contact.

Sincerely,

JAMES L. BLUM,
Acting Director.

APPENDIX J

SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN [WIC] QUESTIONNAIRE

State: _____ Director: _____

Address: _____ Telephone: _____

PROGRAM PARTICIPATION INFORMATION

1. Number of individuals served in Fiscal Year 1986 (10/1/85–9/30/86):

Total_____ Women_____ Infants_____ Children_____

2. Number and rate of individuals eligible, but not participating in program:

Total #_____ Rate_____% Women #_____ Rate_____%

Infants #_____ Rate_____% Children #_____ Rate_____%

3. Form of Delivery (Percentage): Vouncher #_____ Rate_____%

Home-delivered #_____ Rate_____% Warehouse Pickup #_____ Rate_____%

Other (Specify) _____ Number_____ Rate_____%

4. Please explain why this/these method(s) of service delivery is/are used:

_____

_____

_____

5. What recommendations would you offer for improving the availability of WIC services (operational, legislative, etc.)?

_____

_____

FUNDING INFORMATION

1. Federal funding for Fiscal Year 1987: Total $_____

Stability $_____ Equity $_____

2. Is there supplemental support for the program within your State?

Yes_____ No_____

If yes, please specify source: State_____ Local_____ Other_____

_____

Amount of supplementation $_____ In Kind:_____

_____

How is this supplementation implemented?

_____

3. Has the prohibition of a sales tax on food purchased with WIC vouchers enabled you to expand your program? Yes_____ No_____

If yes, please explain how:

POLICY INFORMATION

1. Please indicate major barriers to participation in your program?

2. What three suggestions would you offer for removing these barriers?

a._____

b._____

c._____

3. What innovations have been implemented in your program to expand program participation?

4. How has the priority system affected participation among children?

Not at all_____ Nominally_____ To a great extent_____

What observations do you have about the effects of the priority system:

5. What percentage of the infants in your program are being breastfed?

0-4_____% 5-14_____% 15-24_____% 25-49_____% 50+_____ %

6. What percentage of the infants are breastfed at six months of age?

0-4_____% 5-14_____% 15-24_____% 25-49_____% 50+_____ %

7. What suggestions do you have to promote breastfeeding?

8. How could the system for allocating equity funds be changed to prevent fluctuations in the caseload?

6. What three suggestions would you offer for improving program management without compromising the nutritional integrity of the program?

a._____

b._____

c._____

APPENDIX K

LIST OF RESPONDENTS

STATES

Alabama	Maine	Oklahoma
Alaska	Maryland	Ohio
California	Massachusetts	Oregon
Colorado	Michigan	Pennsylvania
Connecticut	Minnesota	Rhode Island
Delaware	Mississippi	South Carolina
Florida	Missouri	Tennessee
Georgia	Montana	Texas
Hawaii	Nevada	Utah
Idaho	Nebraska	Vermont
Illinois	New Hampshire	Virginia
Indiana	New Jersey	Washington
Iowa	New Mexico	West Virginia
Kansas	New York	Wisconsin
Kentucky	North Carolina	Wyoming
Louisiana	North Dakota	

DISTRICTS, TERRITORIES, INDIAN TRIBES

District of Columbia
Puerto Rico
Virgin Islands
Indian Township (Princeton, Maine)
Penobscot Indian WIC (Old Town, Maine)
ENIPC (San Juan Pueblo, New Mexico)
Eastern Band of Cherokee Indians (Cherokee, NC)
Intertribal Council, Miami, Oklahoma
Oklahoma WCD/WIC Program (Indiana State Agency) (Anadarko)
Tonkawa Tribe, Oklahoma
Shoshone and Arapahoe, Wyoming
Intertribal Council of Nevada, Reno, Nevada
Standing Rock Sioux Tribe, Fort Yates, North Dakota
Cheyenne River Sioux Tribe, Eagle Butte, South Dakota
Navajo Nation (AZ, NM, UT), Window Rock, Arizona
Mississippi Choktaw
Five Sandoval Indian Pueblos, Bernalillo, New Mexico
Acoma-Camoncito-Laguna WIC Program, New Laguna, New Mexico
Rosebud Sioux, Rosebud, South Dakota
Chickasaw Nation, Ada, Oklahoma
Choktaw Nation, Durant, Oklahoma
Cherokee Nation of Oklahoma, Tahlequah, Oklahoma
C.B. Potawatomi Indian Tribe, Shawnee, Oklahoma
Intertribal Council of Arizona, Phoenix, Arizona

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